APPENDIX A

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

1 MEDICARE (Medicare #)	Medicaid (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
☐	☐	☐	☐	☐	☐	☐

1a INSURED'S I D NUMBER (FOR PROGRAM IN ITEM 1)

2 PATIENT'S NAME (Last Name First Name Middle Initial)	3 PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4 INSURED'S NAME (Last Name First Name Middle Initial)
5 PATIENT'S ADDRESS (No Street)	6 PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7 INSURED'S ADDRESS (No Street)
CITY / STATE	8 PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9 OTHER INSURED'S NAME (Last Name First Name Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO	11 INSURED'S POLICY GROUP OR FECA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b EMPLOYER'S NAME OR SCHOOL NAME
c EMPLOYER'S NAME OR SCHOOL NAME	c OTHER ACCIDENT? ☐ YES ☐ NO	c INSURANCE PLAN NAME OR PROGRAM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME	10d RESERVED FOR LOCAL USE	d IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim I also request payment of government benefits either to myself or to the party who accepts assignment below SIGNED DATE		13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below SIGNED

PATIENT AND INSURED INFORMATION

14 DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a I D NUMBER OF REFERRING PHYSICIAN	18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19 RESERVED FOR LOCAL USE		20 OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1 2 3 4		22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO 23 PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

PHYSICIAN OR SUPPLIER INFORMATION

25 FEDERAL TAX I D NUMBER SSN ☐ EIN ☐	26 PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT? (For govt claims, see back) ☐ YES ☐ NO	28 TOTAL CHARGE $	29 AMOUNT PAID $	30 BALANCE DUE $
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33 PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN # GRP #		

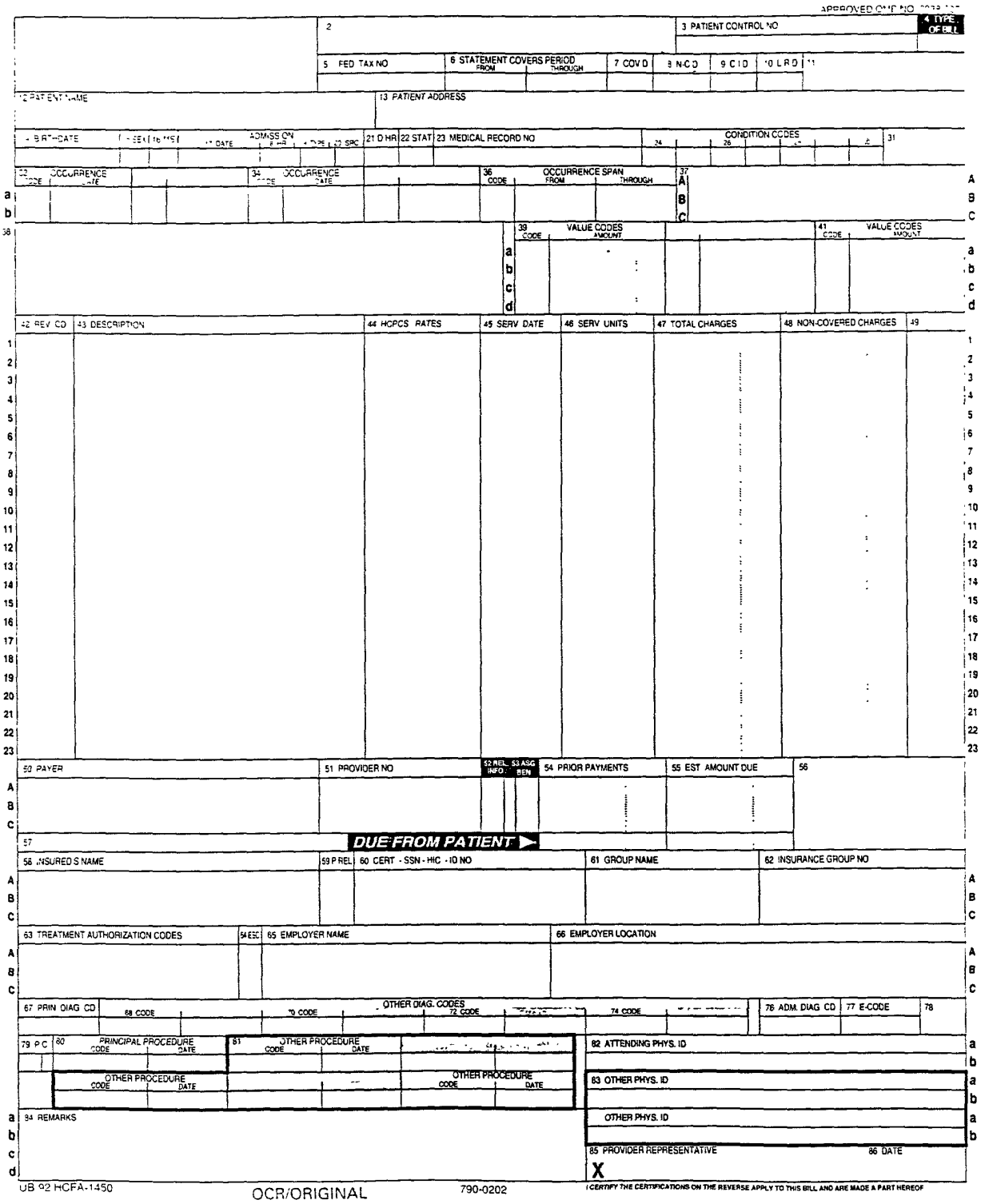
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPENDIX A

APPENDIX B


APPROVED OMB NO
2
3 PATIENT CONTROL NO
4 TYPE OF BILL
5 FED TAX NO
6 STATEMENT COVERS PERIOD FROM THROUGH
7 COV D
8 N-C D
9 C I D
10 L R D
11
12 PATIENT NAME
13 PATIENT ADDRESS
14 BIR-DATE
15 SEX
16 MSF
17 DATE
ADMISS ON
18 HR
19 TYPE
20 SRC
21 D HR
22 STAT
23 MEDICAL RECORD NO
24
CONDITION CODES
26
31
32 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV CD
43 DESCRIPTION
44 HCPCS RATES
45 SERV DATE
46 SERV UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
50 PAYER
51 PROVIDER NO
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST AMOUNT DUE
56
57
DUE FROM PATIENT
58 INSURED S NAME
59 P REL
60 CERT - SSN - HIC - ID NO
61 GROUP NAME
62 INSURANCE GROUP NO
63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN DIAG CD
68 CODE
70 CODE
OTHER DIAG. CODES
72 CODE
74 CODE
76 ADM. DIAG CD
77 E-CODE
78
79 P C
80 PRINCIPAL PROCEDURE CODE DATE
81 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
OTHER PHYS. ID
84 REMARKS
85 PROVIDER REPRESENTATIVE
X
86 DATE
UB 92 HCFA-1450
OCR/ORIGINAL
790-0202
I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

APPENDIX B

APPENDIX C

Exemplary Voice Commands

```
-----Function-----    -----Voice Command-----
.Add vmAppExit, "Exit Computer", "", ""
.Add vmAppExit, "Computer Exit", "", ""

.Add vmUserLogin, "Hello Computer", "", ""
.Add vmUserLogin, "Log Me In", "", ""
.Add vmUserLogin, "Log In", "", ""

.Add vmUserLogout, "Goodbye Computer", "", ""
.Add vmUserLogout, "Log Me Out", "", ""
.Add vmUserLogout, "Log Out", "", ""

.Add vmProfileShow, "Show Profile", "", ""
.Add vmProfileShow, "Show Settings", "", ""

.Add vmPatientSelect, "Patient <1To20>", "", ""
.Add vmPatientSelect, "Select Patient <1To20>", "", ""

.Add vmPatientsShow, "Show Patients", "", ""
.Add vmPatientsShow, "Patient List", "", ""
.Add vmPatientsShow, "Case List", "", ""

.Add vmFormsShow, "Show Forms", "", ""
.Add vmFormsShow, "Show Protocol", "", ""
.Add vmFormsShow, "Protocol List", "", ""

.Add vmProtocolSelect, "_____", "", "" 'valid Protocol file name
.Add vmProtocolSelect, "Use _____", "", "" 'valid Protocol file name

.Add vmRecordBegin, "Begin Dictation", "", ""
.Add vmRecordBegin, "New Dictation ", "", ""
.Add vmRecordBegin, "Start Dictation ", "", ""
.Add vmRecordBegin, "Begin Record", "", ""
.Add vmRecordBegin, "New Record", "", ""
.Add vmRecordBegin, "Start Record", "", ""

.Add vmProtocolEdit, "Edit Protocol", "", ""
.Add vmProtocolEdit, "Edit Form", "", ""

.Add vmRecordHold, "Hold Patient", "", ""
.Add vmRecordHold, "Hold Record", "", ""

.Add vmRecordSign, "My Signature", "", ""
.Add vmRecordSign, "Sign Record", "", ""
.Add vmRecordSign, "Sign the Record", "", ""
.Add vmRecordSign, "Sign Off", "", ""
```

```
.Add vmRecordCancel, "Cancel Form", "", ""
.Add vmRecordCancel, "Cancel Record", "", ""

.Add vmProtocolFieldNext, "Next Field", "", ""
.Add vmProtocolFieldNext, "Advance", "", ""

.Add vmProtocolFieldPrevious, "Previous Field", "", ""
.Add vmProtocolFieldPrevious, "Go Back", "", "
```

United States Patent & Trademark Office

Office of Initial Patent Examination -- Scanning Division

Application deficiencies found during scanning:

☐ Page(s)___________ of ______________________________ were not present for scanning. (Document title)

☐ Page(s)___________ of ______________________________ were not present for scanning. (Document title)

☐ ***Scanned copy is best available.***

- Some drawing figures are very dark.
- Pages numbered 27 to 30 as part of specification are Appendices.